PRV – Electronic Health Record (EHR) Incentive Application

Processing

Purpose:
To administer the EHR Incentive Payment Program

Identification of Roles: EHR Specialists and Coordinator

Performance Standards: Timeframes agreed upon between the Contractor and the Project Director in the project charter

Path of Business Procedure:
Step 1: Application Review

a. Access www.imeincentives.com: Provider Incentive Payment Program(PIPP) System
b. Log into the system-see pg. 10 of PIPP User Manual https://www.imeincentives.com/PublicDoc/UserManualProviderIAFull.pdf
c. Upon log in, the dashboard displays the counts for each status. To get to the outstanding work items, click “my queue” on the left.
d. Click the status drop down box to “application review.”
    1. Click verify application under the action column. The review will be either Adopt, Implement, or Upgrade (AIU) Year 1 or Meaningful Use (MU) Year 2 for Eligible Professional (EP). An Eligible Hospital (EH) could be MU for Year 1, depending on whether they have received a Medicare payment. Check the Centers for Medicare and Medicaid Services (CMS) reports to determine if the hospital received an MU payment. Descriptions for both EP and EH application types can be found on page 53 of the User Manual.
    2. Begin reviewing the application by clicking review on each of the criteria options.
        a) Provider Questions-These questions indicate the provider type, the payee information, practicing locations, pending sanctions, etc. Verify that all of the information provided is accurate. You cannot approve this page until a legacy pay-to number is entered. If this is a 1st year payment, you should approve all the additional pages before creating a legacy for the payee on MMIS. If this is a 2nd year payment, you can enter the legacy created from the year 1 payment if the EP wants the payment to go to the same payee NPI and Tax Identification (ID) as the Year 1 payment. You may click cancel before approving to move on to the remaining criteria pages.

Check the EHR Incentive Program Track Records spreadsheet found in the Provsrv_data share drive in the EHR Incentive Program folder to verify the group is using the same approach to patient volume (individual v. group). Providers within the same group must use the same approach for the entire clinic NPI for the program year.

b) EHR Questions- These questions pertain to the provider's EHR system. Verify the CMS EHR Certification Number matches the uploaded documentation (if applicable). If the EHR certification number didn't change from an earlier approved attestation, then documentation is not required. After reviewing all of the information click approve and ok to move on.

c) Audit- This page displays a summary of the patient encounters and other provider details Upload a screenshot of the Iowa Medicaid Enterprise (IME) claims report to this page. Keep in mind you must set the audit flag before documents are saved to the page.

d) Patient Volume Questions- This page displays information pertaining to the provider's patient volume in the chosen 90-day span. Verify the patient volume is at least 30% for EP's (20% for pediatricians) and 10% for hospitals. Compare the provider's uploaded proof of patient volume document against the numerator and denominator they are attesting with to ensure they match. **Run the data warehouse claims report for the appropriate NPI** for the 90-day period indicated on the attestation. This might be the payee NPI if going clinic level, or could be the rendering NPI if going individual. Log into Remote Desktop Connection. Click on the DBxtra.NET icon, log in. Click on Claim_DSS.Net Project to expand the options. Next expand the Objects. You will have a choice of Claim count by NPI Hospital, Physician and Physician Exclude 21, 23 (only exclude 21, 23 for U of I physicians). Once you have chosen how you would like to run the claims report click on Data Grid. Follow the prompts of NPI, first and last date. The 90-day span needs to be entered as yyyymmdd. The claims report will run and produce the number of PAID claims. Take a screen shot and copy to a word document to be uploaded to the application.

e) Meaningful Use Core Set Questions (Not present in Year 1)- On this page, you will need to verify that the denominator matches on the applicable questions. Each yes or no question should be answered yes. After reviewing the information provided, click approve and ok. Hospitals should have answered these questions at CMS first and should not be completing the MU pages. Hospitals who try to attest with Medicaid first should be instructed to attest at Medicare first for meaningful use, before attesting with Medicaid.

f) Meaningful Use Menu Set Questions (Not present in Year 1)-Verify that all questions have been answered, click approve and ok.

g) Meaningful Use Clinical Quality Measures (Not present in Year 1)-Verify that the provider has entered a number in all of the fields click approve and ok.

h) If there is any information that was entered incorrectly by the provider, you should return the application to the provider to correct. Click on the return to provider option and select the appropriate reasons. This will send the application back to the provider with an email letting them know specifically why it was returned.

i) After you have reviewed and approved/denied all of the criteria pages, the "forward to secondary review" button will appear. Clicking this button sends the application to the next reviewer.

Step 2: Secondary Application Review –

a. Follow all of the steps from the application review process. After you have verified the information, reviewed all documentation, and checked any notes added by the first review, and checked the EHR Incentive Program Track Records spreadsheet (Provsrv_data share drive in the EHR Incentive Program folder) you may click the "finalize" button to send the application for payment or return to provider if needed. If both reviewers do not agree on the approval of the application, it will go into the supervisor review status. Once the application has reached the "payment complete" status, enter the payment information into the spreadsheet.

Step 3: Supervisor Review—

a. Follow all of the steps from the application review process. After you have verified the information, reviewed all documentation, and checked any notes added by the first review and second reviewers, either deny or approve the application.

Forms/Reports:

Denial letter

RFP References:

6.4.4.3.a

Interfaces:

MMIS
CMS Registration and Attestation System

Attachments:

E-HR INCENTIVE PAYMENT

E-HR Program Specialist